



Out Of State Verification Of Registration/Certification/Licensure As A Chemical Dependency Professional

APPLICANT'S NAME	DATE OF BIRTH (MO/DAY/YR)
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I, _____, Secretary of _____ hereby
OFFICIAL NAME OF BOARD

certify that _____ was granted State Registration/Certification/Licensure
APPLICANT'S NAME

Number _____ to practice _____ in the

State of _____ on the _____ day of _____, 20 ____ on the basis of:

- Successfully passing the required examination
- Grandparenting

Did the applicant take and pass the **NAADAC exam?** Yes No Score _____

Did the applicant take and pass the **ICRC level II or higher exam?** Yes No Score _____

Required Education? _____

Required Experience? _____

Status of credential: Current Expiration Date _____
 Expired Date _____

Legal/Disciplinary Action: Yes No

If yes, explain and provide any applicable documentation:

I further certify that the preliminary and professional education of this applicant was verified by this Board prior to the examination of the applicant.

Acting on behalf of the _____ SECRETARY _____ DATE _____

OFFICIAL NAME OF BOARD _____

TELEPHONE _____

State
Seal

Return to: Chemical Dependency Professionals Program
PO Box 47869
Olympia, WA 98504-7869